



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA, TX 77504

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name

HIGHLANDS INSURANCE CO

Carrier's Austin Representative Box

BOX NUMBER 01

MFDR Tracking Number

M4-07-3579-01

MFDR Date Received

FEBRUARY 6, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 21, 2007: "Carrier may reimburse at a "per diem" rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached."

Amount in Dispute: \$28,377.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated February 23, 2007: This hospital bill concerns a two-day hospitalization and surgical procedure of the removal of a pedicle screw at the L5-S1 level on the left. The insurance carrier reimbursed the hospital pursuant to the per diem method of reimbursement of the Inpatient Hospital Fee Guideline. Initially, the hospital was reimbursed \$1,118 for a one-day stay. On reconsideration, the hospital was reimbursed another \$1,118, for a total reimbursement of \$2,236 for a two-day inpatient surgical stay. The hospital has not shown that reimbursement should have been pursuant to the stop-loss method of reimbursement of the *Acute Care Inpatient Hospital Fee Guideline*. The surgical procedure and recovery were without complications and the hospital has not shown that the hospitalization required unusually extensive or costly services. Additionally, the provider has not contended in this medical dispute that it should be paid pursuant to the stop-loss provision of the *Acute Care Inpatient Hospital Fee Guideline*. According to the documents submitted during the medical dispute process, the provider contends that it should not have been reimbursed at the per diem method but, instead, at 70% of its charges if the bill exceeded \$75,000. The charges for the two-day hospitalization were \$40,818.18 and did not exceed \$75,000. Therefore, even under the contention of the hospital, the bill would be paid at the per diem amount of reimbursement."

Response Submitted by: Beverly Vaughn for Highlands Ins

Respondent's Supplemental Position Summary Dated March 14, 2007: "According to the documents submitted during the medical dispute process, the provider contends that it should not have been reimbursed at the per diem method but, instead, at 70% of its charges if the bill exceeded \$75,000. The charges for the two-day hospitalization were \$40,818.18 and did not exceed \$75,000. In the additional documents, the provider now takes the position that the hospital should be reimbursed pursuant to the stop-loss method of reimbursement under the *Acute Care Inpatient Hospital Fee Guideline*. The surgical procedure and recovery were without complications and the hospital has not shown that the hospitalization required unusually extensive or costly services ... Under the Division's current policy, to be reimbursed pursuant to the stop-loss method, a hospital must show that the hospital stay involved unusually extensive or costly services. In this case the hospital has presented no documents showing the hospitalization should be reimbursed at anything other than the per-diem method of reimbursement."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law

Respondent's Supplemental Position Summary Dated August 29, 2011: "This medical dispute involves a two-day hospitalization at Vista Hospital for the surgical procedure of removal of a pedicle screw at the L5-S1 level on the left. For this two day stay, Vista charged \$40,818.18. The insurance carrier reimbursed the hospital at the surgical per diem rate of \$1,118 a day for two days, for a total reimbursement of \$2,236.00. This hospitalization was for the surgical removal of a pedicle screw ... The discharge summary ... indicates that the procedure was performed "without any problems", the patient was up and ambulating on the day of surgery and "continued to do well," the patient's drain was removed the second day and he was discharged home. The hospital records do not support that this hospitalization involved unusually extensive or unusually costly services. Therefore, the hospital has not shown it is entitled to additional reimbursement."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 5, 2006 through October 7, 2006	Inpatient Hospital Services	\$28,377.64	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 45 – Charges exceed your contracted/legislated fee arrangement.
- 855-002 – Recommended allowance is in accordance with workers compensation medical fee schedule guidelines \$0.00.
- 855-002 – Recommended allowance is in accordance with workers compensation medical fee schedule guidelines \$1,118.00.
- 900-021 – Any network reduction is in accordance with the network referenced above.
- W1 – Workers compensation state fee schedule adjustment. \$0.00

- W1 – Workers compensation state fee schedule adjustment. \$1,118.00
- Upon further review, an additional allowance is being recommended at the inpatient per diem for a 2 day stay.
- 855-002 – Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines; \$2,236.00.
- W1 – Workers Compensation State Fee Schedule Adjustment \$2,236.00.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The documentation filed to the division by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, and 28 Texas Administrative Code §134.401(c)(6), the division will address whether the requestor demonstrated that: audited charges **in this case** exceed \$40,000; the admission and disputed services **in this case** are unusually extensive; and that the admission and disputed services **in this case** are unusually costly.

1. 28 Texas Administrative Code §133.240(a) and (e), 31 Texas Register 3544, effective May 2, 2006 and applicable to the dates of service, state, in pertinent part, that " (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill..." and "(e) The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division..." Furthermore, 28 Texas Administrative Code §133.2, 31 Texas Register 3544, states, in pertinent part "(4) Final action on a medical bill-- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

The requestor in its position statement asserts that:

"The Carrier also did not make a legal denial of reimbursement when it did take final action on the medical bills because it did not provide payment exception codes required by the Division's Rules and instructions and Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration."

Review of the submitted documentation finds that the explanation of benefits was issued using the division prescribed form TWCC 62 and noted payment exception codes of:

- 45 – Charges exceed your contracted/legislated fee arrangement.
- 855-002 – Recommended allowance is in accordance with workers compensation medical fee schedule guidelines \$0.00.
- 855-002 – Recommended allowance is in accordance with workers compensation medical fee schedule guidelines \$1,118.00.
- 900-021 – Any network reduction is in accordance with the network referenced above.
- W1 – Workers compensation state fee schedule adjustment. \$0.00
- W1 – Workers compensation state fee schedule adjustment. \$1,118.00
- Upon further review, an additional allowance is being recommended at the inpatient per diem for a 2 day stay.

- 855-002 – Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines; \$2,236.00.
- W1 – Workers Compensation State Fee Schedule Adjustment \$2.236.00.

These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s) for the services in dispute. The division therefore concludes that the insurance carrier has met the requirements of applicable §133.240, and §133.2.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$40,818.18. The division concludes that the total audited charges exceed \$40,000.
3. The requestor in its original position statement asserts that "...if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor's position that it was not required to prove that the services in disputes were unusually extensive is not supported. The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services, therefore, the division finds that the requestor did not meet 28 TAC §134.401(c) (6).
4. In regards to whether the services were unusually costly, the requestor states "...The rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly..." The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's position that it was not required to prove that the services in disputes were unusually extensive is not supported. The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually costly services, therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was two days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of two days results in an allowable amount of \$2,236.00.
 - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed two units of Thrombin USP TOP at \$330.05/unit, for a total charge of \$660.10. The requestor did not submit documentation to support what the cost to the hospital was for Thrombin USP TOP. For that reason, reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$2,236.00. The respondent issued payment in the amount of \$2,236.00. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>October 4, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	<u>October 4, 2012</u>
Signature	Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.